

Viral Hepatitis Case Report

Hepatitis E

Michigan Department of Community Health

Communicable Disease Division

Investigation Information					
Investigation ID	Onset Date mm/dd/yyyy	Diagnosis Date mm/dd/yyyy	Referral Date mm/dd/yyyy	Case Entry Date mm/dd/yyyy 09/13/2013	Case Completion Date mm/dd/yyyy
Investigation Status NEW			Case Status <input type="radio"/> Confirmed <input type="radio"/> Not a Case <input type="radio"/> Probable <input type="radio"/> Suspect <input type="radio"/> Unknown		
Patient Status <input type="checkbox"/>	Patient Status Date mm/dd/yyyy 09/13/2013	Part of an outbreak? <input type="checkbox"/>	Outbreak Name	Case Updated Date mm/dd/yyyy 09/13/2013	
Patient Information					
Patient ID	First	Last	Middle		
Street Address					
City	County	State	Zip		
Home Phone ###-###-####	Ext.	Other Phone ###-###-####	Ext.		
Parent/Guardian (required if under 18)					
First		Last	Middle		
Demographics					
Sex <input type="radio"/> Male <input type="radio"/> Female <input type="radio"/> Unknown	Date of Birth mm/dd/yyyy	Age	Age Units <input type="radio"/> Days <input type="radio"/> Months <input type="radio"/> Years		
Race (Check all that apply) <input type="checkbox"/> Caucasian <input type="checkbox"/> African American <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Hawaiian/Pacific Islander <input type="checkbox"/> Asian <input type="checkbox"/> Unknown <input type="checkbox"/> Other (Specify)					
Hispanic Ethnicity <input type="radio"/> Hispanic/Latino <input type="radio"/> Non-Hispanic/Latino <input type="radio"/> Unknown			Arab Ethnicity <input type="radio"/> Arab <input type="radio"/> Non-Arab <input type="radio"/> Unknown		
Worksites/School			Occupations/Grade		
Referral Information					
Person Providing Referral					
First	Last	Phone ###-###-####	Ext.	Email	

Case ID

First Name

Last Name

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Referral Information cont.*Primary Physician*

First <input type="text"/>	Last <input type="text"/>	Phone ###-###-#### <input type="text"/>	Ext. <input type="text"/>	Email <input type="text"/>
Street Address <input type="text"/>				
City <input type="text"/>	County <input type="text"/>	State <input type="text"/>	Zip <input type="text"/>	

Case ID

First Name

Last Name

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Hospital Information

Patient Hospitalized <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	Hospital _____	Hospital City _____	Hospital Record No. _____
Admission Date mm/dd/yyyy _____	Discharge Date mm/dd/yyyy _____	Days Hospitalized _____	

Clinical Information and Patient History

Place of Birth: <input type="radio"/> USA <input type="radio"/> Other _____	Did the patient die from hepatitis? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	If yes, specify the date of death: mm/dd/yyyy _____											
Reason for Testing: (Check all that apply) <table border="0"><tr><td><input type="checkbox"/> Symptoms of acute hepatitis</td><td><input type="checkbox"/> Evaluation of elevated liver enzymes</td></tr><tr><td><input type="checkbox"/> Screening of asymptomatic patient with reported risk factors</td><td><input type="checkbox"/> Blood / Organ donor screening</td></tr><tr><td><input type="checkbox"/> Screening of asymptomatic patient with no risk factors (e.g., patient requested)</td><td><input type="checkbox"/> Follow-up testing for previous marker of viral hepatitis</td></tr><tr><td><input type="checkbox"/> Prenatal screening</td><td><input type="checkbox"/> Unknown</td></tr><tr><td><input type="checkbox"/> Other _____</td><td></td></tr></table>				<input type="checkbox"/> Symptoms of acute hepatitis	<input type="checkbox"/> Evaluation of elevated liver enzymes	<input type="checkbox"/> Screening of asymptomatic patient with reported risk factors	<input type="checkbox"/> Blood / Organ donor screening	<input type="checkbox"/> Screening of asymptomatic patient with no risk factors (e.g., patient requested)	<input type="checkbox"/> Follow-up testing for previous marker of viral hepatitis	<input type="checkbox"/> Prenatal screening	<input type="checkbox"/> Unknown	<input type="checkbox"/> Other _____	
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<input type="checkbox"/> Prenatal screening	<input type="checkbox"/> Unknown												
<input type="checkbox"/> Other _____													
Is the patient symptomatic? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	Is or was the patient jaundiced? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	Is or was the patient pregnant? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	If yes, specify the due or delivery date: mm/dd/yyyy _____										
Diagnosis: (Check all that apply) <table border="0"><tr><td><input type="checkbox"/> Acute hepatitis A</td><td><input type="checkbox"/> Acute hepatitis B</td><td><input type="checkbox"/> Acute hepatitis C</td></tr><tr><td><input type="checkbox"/> Acute hepatitis E</td><td><input type="checkbox"/> Chronic HBV infection</td><td><input type="checkbox"/> HCV infection (chronic or resolved)</td></tr><tr><td><input type="checkbox"/> Acute non-ABCD hepatitis</td><td><input type="checkbox"/> Perinatal HBV infection</td><td><input type="checkbox"/> Hepatitis Delta (co- or super-infection)</td></tr></table>				<input type="checkbox"/> Acute hepatitis A	<input type="checkbox"/> Acute hepatitis B	<input type="checkbox"/> Acute hepatitis C	<input type="checkbox"/> Acute hepatitis E	<input type="checkbox"/> Chronic HBV infection	<input type="checkbox"/> HCV infection (chronic or resolved)	<input type="checkbox"/> Acute non-ABCD hepatitis	<input type="checkbox"/> Perinatal HBV infection	<input type="checkbox"/> Hepatitis Delta (co- or super-infection)	
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Diagnostic Tests

Test Name	Result
	(P=Positive N=Negative UNK=Unknown)
Total antibody, hepatitis A virus [total anti-HAV]	<input type="text"/>
IgM antibody to hepatitis A virus [IgM anti-HAV]	<input type="text"/>
Hepatitis B surface antigen [HBsAg]	<input type="text"/>
Total antibody, hepatitis B core antigen [Total anti-HBc]	<input type="text"/>
IgM antibody, hepatitis B core antigen [IgM anti-HBc]	<input type="text"/>
Antibody to hepatitis D virus [anti-HDV]	<input type="text"/>
Antibody to hepatitis E virus [anti-HEV]	<input type="text"/>
Antibody to hepatitis C virus [anti-HCV]	<input type="text"/>
Supplemental anti-HCV assay [e.g., RIBA]	<input type="text"/>
HCV RNA [e.g., PCR]	<input type="text"/>
anti-HCV signal to cut-off ratio _____	

Liver Enzyme Levels at Time of Diagnosis

Test Name	Result	Upper Limit Normal	Date of Result
			(mm/dd/yyyy)
ALT (SGPT)	<input type="text"/>	<input type="text"/>	<input type="text"/>
AST (SGOT)	<input type="text"/>	<input type="text"/>	<input type="text"/>

[illegible]

Case ID	First Name	Last Name	Viral Hepatitis Case Report	Page 5
Other Information				
Local 1		Local 2		
Name of Person interviewed	Relationship to patient	Date of interview mm/dd/yyyy		
Submitted by:	Date mm/dd/yyyy	Health Department	Phone Number ###-###-####	Ext.

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Other Information cont.				
Comments or Additional Information				

Case ID

First Name

Last Name

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Case Notes

Notes